earlier was in consequence probably of the fear that the very act of dragging out the bowel might favor the development of gangrene. The two cases of Rovsing and Graefe prove that even very suspicious loops incarcerated for several days may recover under this treatment. —*Centralblatt f. Chirg.*, 1892, July 16.

VIII. Treatment of Gangrenous Herniæ. By Dr. POULSEN (Copenhagen). P. long ago advocated the establishment of an artificial anus instead of resection in case of gangrenous herniæ. He still adheres to this opinion knowing that resection was generally followed by better results, but he claims that the establishment of an artificial anus will yield better results if his own method of procedure be adopted. The technique is as follows: after opening and irrigating the hernial sac, enlarge the incision in the abdominal wall two to three centimetres; then draw out the bowel and suture (through the serous coat only) it to the abdominal wall, so that from five to fifteen centimetres of healthy bowel be exposed. Should perforation occur, close this exposed part with Péan's forceps and wrap in iodoform gauze. After one or two days the loop is destroyed by the thermo-cautery, the enterotome used and enteroplasty performed. P. treated five cases of gangrenous herniæ by the above method. Of these three were cured and two were fatal.—*Centralblatt f. Chirg.*, 1892, No. 30.

IX. Treatment of Strangulated Gangrenous Hernia. By Dr. JULES MARIN (Paris). Primary resection and suture is advocated very decidedly, in the treatnent of gangrenous hernia and the formation of a preternatural anus unqualifiedly condemned. The argument is brought forward that collapse in consequence of strangulation followed by gangrene is rare in strong persons in middle age, and therefore can but seldom contra-indicate enterectomy and suturing. The author describes a procedure proposed by Chaput and Duchamp, the essential point of which is the immediate removal of the spur resulting from an artificial anus, by primary longitudinal splitting and subsequent suturing. After circular resection of the gangrenous portion, with or without cuneiform excision of the mesentery, both open ends of the divided bowel are placed side by side. In each a longitudinal incision of from six to eight centimeters is made, one to two centimeters distant from the insertion of the mesentery. Then the four edges of the two longitudinal splits in the intestine are sutured so that both lumina of the bowel freely communicate. After this suturing (longitudinal enterorraphy) the two ends of the bowel form a condition like a pair of trousers, whose common upper broad opening still requires closing. This closure may be made completely or a small opening may be left as a kind of safety-valve, and its edges sutured to the hernial sac. The latter course is usually preferred by Chaput and Duchamp, the fistulous opening which results closing spontaneously or subsequently requiring but a slight freshening of the edges, and suturing. This course involves complete renouncing of the method of reposition of the closed bowel.

The disadvantages to which this portion of the procedure may lead is shown by the course pursued by a case operated upon by Duchamp. The symptoms of strangulation did not cease, and it was only after the introduction of a catheter through the fistula into the upper end of the bowel that fecal matter escaped. An artificial anus resulted, which was closed by a later operation. The cause of this complication resided in the narrow canal itself. The pressure exercised upon the walls of the ends of the bowel prevented the escape of fecal matter from the opening, as well as communication through the slit in the spur. M. in order to avoid this, recommends either reposition of the completely sutured intestine or a greater length than eight centimeters to the longitudinal slit.

The first patient operated upon by Duchamp recovered without any disturbance of the course of healing whatever, the small fistulous opening closing spontaneously. In Chaput's case the cure of an artificial anus, which had resisted other measures, was attempted. The patient from excessive weakness proved to be an unfavorable subject for operation, and died two days afterwards. The autopsy showed no sufficient cause of death, no peritonitis existed.—*Brochure,* 1892.

(The value of this method can only be determined after more extensive trials. It should be said, so far as the remark concerning the rarity of collapse following strangulation and gangrene of intestine is concerned that experience does not bear out the assertion made. Collapse does occur, and that rather frequently. So pronounced has this been in several instances that I have been constrained to deny the patient a general anæsthetic and have operated under cocaine instead. There can be no question that the fate of the patient frequently depends upon the rapid completion of the operation. As to the length of the slit in the spur: this should be not less than ten centimeters after the parts are entirely healed.)

GEORGE RYERSON FOWLER (Brooklyn.)

EXTREMITIES.

I. Subperiosteal Excision of the Tarsus, and of the Proximal Extremities of Fourth and Fifth Metatarsal Bones for Caries, with Perfect Preservation of the Shape and Functions of the Foot. By Dr. DON EMILIO REINA G. MARTIN (Spain). The patient, a child eight years of age, had a tubercular anthritis of the ankle-joint, with numerous fistulæ on dorsal and plantar surfaces of the foot. Two large incisions along the foot starting underneath the malleoli and terminating in the distal quarter of the first and fifth metatarsal bones were made and then two vertical incisions were made to increase the room. All the soft parts of the dorsal region were dissected up and the diseased bones were excavated by gouge and trephine. The calcaneus, astragalus, scaphoid, cuboid and the proximal extremities of the fourth and fifth metatarsal bones were scooped out with the exception of the thinnest possible shell, which was retained as a "mould" for the periosteum and to aid in the regeneration of new bone. An aperture for drainage was made in each bone. The bone cavities were carefully disinfected, drainage tubes inserted, the soft parts sutured, and an iodoform poultice and a retentive dressing was applied.

The foot is now perfectly healed, of normal shape and length, with the exception of a slight contraction of the calcaneus which renders the heel slightly less prominent than normal. The functions of the joints and foot are normal.—*Revista Medica de Sevilla,* Dec. 15, 1891.

SAMUEL LLOYD (New York).